

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9579

## CERTIFICATE OF DEATH

Reg. Dist. No.

09533

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Road P.O. Box</u>				d. STREET ADDRESS <u>P.O. Box</u>			
3. NAME OF DECEASED (Type or print) First <u>Greenby</u> Middle <u>Brooks</u> Last <u>Brooks</u>				4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-16-1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>22</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			
11. BIRTHPLACE (State or foreign country) <u>md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Perry Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Georgiana Fields</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>11</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Marietta Green, Oxford, md.</u>				Address <u>Oxford, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute upper respiratory infection</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>8/19</u> , 19 <u>59</u> , to <u>8/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/22</u> , 19 <u>59</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>L. J. Ehliseder</u> M.D.							
PHYSICIAN'S NAME (Type) <u>L. J. Ehliseder</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (city, town, or county) (State)	
<u>Burial</u>		<u>8-25-59</u>		<u>Odd Fellow Lodge Cem</u>		<u>N.R. Oxford, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>As. B. Vashell</u>				ADDRESS <u>Easton, md.</u>		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE <u>C. P. R. H. H. H.</u>				DATE <u>AUG 27 '59</u>			

2562

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9559

CERTIFICATE OF DEATH

Reg. Dist. No.

09534

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FEDERALSBURG</u> 05x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>		d. STREET ADDRESS <u>RFD #2 Box 245</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA GERTRUDE BRUMMELL</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 17 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS TILGHAM</u>		14. MOTHER'S MAIDEN NAME <u>MARY PHILLIPS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>CHARLES BRUMMELL</u>		Address <u>FEDERALSBURG, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>330x</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic inflammatory disease, rt. lung, etiology unknown</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>unknown</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/2/59</u> to <u>8/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/16</u> , 19 <u>59</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u>8-19-59</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>202 Dover St.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FEDERAL HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton Son</u>		ADDRESS <u>Federalburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>WILLIAM J. BROWN</i>		DATE OF DEATH <i>10-15-1918</i>	
RESIDENCE <i>1234 E. BALTIMORE ST.</i>		PLACE OF DEATH <i>HOME</i>	
AGE <i>45</i>		SEX <i>MALE</i>	
OCCUPATION <i>CLERK</i>		CAUSE OF DEATH <i>HEART DISEASE</i>	
DATE OF BIRTH <i>1873</i>		PLACE OF BIRTH <i>MD</i>	
MARRIED <i>YES</i>		SINGLE <i>NO</i>	
EDUCATION <i>HIGH SCHOOL</i>		RELIGION <i>METHODIST</i>	
MILITARY SERVICE <i>NO</i>		NAVY SERVICE <i>NO</i>	
PREVIOUS ILLNESS <i>NO</i>		PREVIOUS SURGERY <i>NO</i>	
DATE OF ONSET <i>10-10-18</i>		DATE OF DEATH <i>10-15-18</i>	
TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>HOME</i>	
MANNER OF DEATH <i>NATURAL</i>		MANNER OF DEATH <i>NATURAL</i>	
SIGNATURE OF PHYSICIAN <i>W. J. BROWN</i>		SIGNATURE OF DECEASED <i>W. J. BROWN</i>	
SIGNATURE OF WITNESS <i>W. J. BROWN</i>		SIGNATURE OF WITNESS <i>W. J. BROWN</i>	
DATE OF SIGNATURE <i>10-15-18</i>		DATE OF SIGNATURE <i>10-15-18</i>	
PLACE OF SIGNATURE <i>HOME</i>		PLACE OF SIGNATURE <i>HOME</i>	
MANNER OF SIGNATURE <i>NATURAL</i>		MANNER OF SIGNATURE <i>NATURAL</i>	
SIGNATURE OF DECEASED <i>W. J. BROWN</i>		SIGNATURE OF DECEASED <i>W. J. BROWN</i>	
SIGNATURE OF WITNESS <i>W. J. BROWN</i>		SIGNATURE OF WITNESS <i>W. J. BROWN</i>	
DATE OF SIGNATURE <i>10-15-18</i>		DATE OF SIGNATURE <i>10-15-18</i>	
PLACE OF SIGNATURE <i>HOME</i>		PLACE OF SIGNATURE <i>HOME</i>	
MANNER OF SIGNATURE <i>NATURAL</i>		MANNER OF SIGNATURE <i>NATURAL</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
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VS A15 (4)  
15M 9/55

9560

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

09535

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL</b>		d. STREET ADDRESS <b>05x-2</b>	
3. NAME OF DECEASED (Type or print) <b>HARRY</b> First <b>EDWARD</b> Middle <b>BULLOCK</b> Last		4. DATE OF DEATH <b>AUGUST</b> Month <b>12</b> Day <b>1959</b> Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 17, 1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HUCKSTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>	9. AGE (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE ALFRED BULLOCK</b>		14. MOTHER'S MAIDEN NAME <b>MARY MINER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>203-18-5356</b>	
17. INFORMANT <b>SON</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte imbalance</b> <b>545x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Phycho obstruction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19</b> to <b>19</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>4:25</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>2195 Washington ST BALTIMORE</b> DATE SIGNED <b>Aug 59</b>	
ACTUAL SIGNATURE <b>E. C. H. Schmidt</b> M.D.		PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b> <b>Easton 16, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>Aug 13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>DENTON</b>		22d. LOCATION (City, town, or county) (State) <b>DENTON MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. V. Moor &amp; Son</b> ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 17 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraw</b>	





9580

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G246 8-17-59 et

## CERTIFICATE OF DEATH

09536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b>				c. LENGTH OF STAY IN 1b <b>3 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. STREET ADDRESS -----			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>L.</b> Last <b>BUTLER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>6</b> , Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1867</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Mitchell, Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Boland</b>				14. MOTHER'S MAIDEN NAME <b>Catherine A. O'Donnell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT Address <b>Mrs. Catherine B. Jackson, St. Michaels</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic cardiovascular</b> DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cachexia, generalized.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 wks.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-27-1955</b> to <b>8-6-1959</b> , that I last saw the deceased alive on <b>8-6-1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, State) DATE SIGNED							
ACTUAL SIGNATURE <b>Thymy M. Beeser Jr.</b> M.D. <b>St. Michaels Md</b>				PHYSICIAN'S NAME (Type) <b>Thymy M. Beeser Jr.</b> <b>8-7-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bedford, Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hamberton Harrison</b>				ADDRESS <b>St. Michaels</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Orthur L. Hines</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VS A15 (4)  
ISM 9/55

1  
9561  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

119538

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg - Rural</u> <u>05X-2</u>	
4. DATE OF DEATH First Middle Last <u>HAROLD JAMES DEW</u>		d. STREET ADDRESS <u>Near Chestnut Grove</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1896</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST (Wholesale)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONN. (Bridgeport)</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES DEW</u>		14. MOTHER'S MAIDEN NAME <u>ELLA BELOVA Relyea</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>216-18-5981</u>	
17. INFORMANT <u>Mrs. Flossie A. Dew, Federalburg, Md., RFD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 Aug</u> , 19 <u>59</u> , to <u>28 Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>28 Aug</u> , 19 <u>59</u> , and that death occurred at <u>12:20 P</u> M, from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Caroline Maryland</u> DATE SIGNED <u>28 Aug 59</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 31, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son</u>		ADDRESS <u>Federalburg</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



## MEDICAL CERTIFICATION

VS A15 (4)  
ISM 9/55

CERTIFICATE OF DEATH

2568

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12/5/29		6. BIRTH PLACE MOBILE, ALA.	
7. DECEASED AT BALTIMORE, MD		8. DECEASED ON 4/4/68		9. DECEASED AT HOSPITAL	
10. CAUSE OF DEATH Suicide by gunshot		11. MANNER OF DEATH Homicide		12. PLACE OF DEATH HOSPITAL	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF WITNESS (None)		15. SIGNATURE OF PHYSICIAN (None)	
16. SIGNATURE OF CORONER (None)		17. SIGNATURE OF JURY (None)		18. SIGNATURE OF JUDGE (None)	
19. SIGNATURE OF CLERK (None)		20. SIGNATURE OF REGISTRAR (None)		21. SIGNATURE OF NOTARY (None)	
22. SIGNATURE OF DECEASED'S NEXT OF KIN (None)		23. SIGNATURE OF DECEASED'S ATTORNEY (None)		24. SIGNATURE OF DECEASED'S MINISTER (None)	
25. SIGNATURE OF DECEASED'S PRIEST (None)		26. SIGNATURE OF DECEASED'S RABBI (None)		27. SIGNATURE OF DECEASED'S OTHER (None)	
28. SIGNATURE OF DECEASED'S OTHER (None)		29. SIGNATURE OF DECEASED'S OTHER (None)		30. SIGNATURE OF DECEASED'S OTHER (None)	
31. SIGNATURE OF DECEASED'S OTHER (None)		32. SIGNATURE OF DECEASED'S OTHER (None)		33. SIGNATURE OF DECEASED'S OTHER (None)	
34. SIGNATURE OF DECEASED'S OTHER (None)		35. SIGNATURE OF DECEASED'S OTHER (None)		36. SIGNATURE OF DECEASED'S OTHER (None)	
37. SIGNATURE OF DECEASED'S OTHER (None)		38. SIGNATURE OF DECEASED'S OTHER (None)		39. SIGNATURE OF DECEASED'S OTHER (None)	
40. SIGNATURE OF DECEASED'S OTHER (None)		41. SIGNATURE OF DECEASED'S OTHER (None)		42. SIGNATURE OF DECEASED'S OTHER (None)	
43. SIGNATURE OF DECEASED'S OTHER (None)		44. SIGNATURE OF DECEASED'S OTHER (None)		45. SIGNATURE OF DECEASED'S OTHER (None)	
46. SIGNATURE OF DECEASED'S OTHER (None)		47. SIGNATURE OF DECEASED'S OTHER (None)		48. SIGNATURE OF DECEASED'S OTHER (None)	
49. SIGNATURE OF DECEASED'S OTHER (None)		50. SIGNATURE OF DECEASED'S OTHER (None)		51. SIGNATURE OF DECEASED'S OTHER (None)	
52. SIGNATURE OF DECEASED'S OTHER (None)		53. SIGNATURE OF DECEASED'S OTHER (None)		54. SIGNATURE OF DECEASED'S OTHER (None)	
55. SIGNATURE OF DECEASED'S OTHER (None)		56. SIGNATURE OF DECEASED'S OTHER (None)		57. SIGNATURE OF DECEASED'S OTHER (None)	
58. SIGNATURE OF DECEASED'S OTHER (None)		59. SIGNATURE OF DECEASED'S OTHER (None)		60. SIGNATURE OF DECEASED'S OTHER (None)	
61. SIGNATURE OF DECEASED'S OTHER (None)		62. SIGNATURE OF DECEASED'S OTHER (None)		63. SIGNATURE OF DECEASED'S OTHER (None)	
64. SIGNATURE OF DECEASED'S OTHER (None)		65. SIGNATURE OF DECEASED'S OTHER (None)		66. SIGNATURE OF DECEASED'S OTHER (None)	
67. SIGNATURE OF DECEASED'S OTHER (None)		68. SIGNATURE OF DECEASED'S OTHER (None)		69. SIGNATURE OF DECEASED'S OTHER (None)	
70. SIGNATURE OF DECEASED'S OTHER (None)		71. SIGNATURE OF DECEASED'S OTHER (None)		72. SIGNATURE OF DECEASED'S OTHER (None)	
73. SIGNATURE OF DECEASED'S OTHER (None)		74. SIGNATURE OF DECEASED'S OTHER (None)		75. SIGNATURE OF DECEASED'S OTHER (None)	
76. SIGNATURE OF DECEASED'S OTHER (None)		77. SIGNATURE OF DECEASED'S OTHER (None)		78. SIGNATURE OF DECEASED'S OTHER (None)	
79. SIGNATURE OF DECEASED'S OTHER (None)		80. SIGNATURE OF DECEASED'S OTHER (None)		81. SIGNATURE OF DECEASED'S OTHER (None)	
82. SIGNATURE OF DECEASED'S OTHER (None)		83. SIGNATURE OF DECEASED'S OTHER (None)		84. SIGNATURE OF DECEASED'S OTHER (None)	
85. SIGNATURE OF DECEASED'S OTHER (None)		86. SIGNATURE OF DECEASED'S OTHER (None)		87. SIGNATURE OF DECEASED'S OTHER (None)	
88. SIGNATURE OF DECEASED'S OTHER (None)		89. SIGNATURE OF DECEASED'S OTHER (None)		90. SIGNATURE OF DECEASED'S OTHER (None)	
91. SIGNATURE OF DECEASED'S OTHER (None)		92. SIGNATURE OF DECEASED'S OTHER (None)		93. SIGNATURE OF DECEASED'S OTHER (None)	
94. SIGNATURE OF DECEASED'S OTHER (None)		95. SIGNATURE OF DECEASED'S OTHER (None)		96. SIGNATURE OF DECEASED'S OTHER (None)	
97. SIGNATURE OF DECEASED'S OTHER (None)		98. SIGNATURE OF DECEASED'S OTHER (None)		99. SIGNATURE OF DECEASED'S OTHER (None)	
100. SIGNATURE OF DECEASED'S OTHER (None)		101. SIGNATURE OF DECEASED'S OTHER (None)		102. SIGNATURE OF DECEASED'S OTHER (None)	

NOTARY PUBLIC

9581

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>	
c. LENGTH OF STAY IN 1b <b>1 yr.</b>		d. STREET ADDRESS <b>Maple Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>-----</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>E.</b> Last <b>GERMAN</b>		4. DATE OF DEATH Month <b>August 10,</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	IF UNDER 24 HRS. Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired, state so) <b>retired cable splicer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Tele Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles R. German</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Lowman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-0940A</b>	
17. INFORMANT <b>Mrs. Charles E. German, St. Michaels, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Heart Dis</b> DUE TO (c) <b>Arteriosclerosis - Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 yr</b> <b>10 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1959</b> to <b>12 Aug 1959</b> , that I last saw the deceased alive on <b>10 Aug 1959</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. Russell Liberty</b> M.D.		ADDRESS (Street, city or town, state) <b>Box 987, St. Michaels, Md</b>	
DATE SIGNED <b>8-10-59</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug 13, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harrison St. Michael</b>		ADDRESS <b>St. Michael</b>	
24a. REC'D BY REGISTRAR <b>Aug 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. German</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

9582

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10668

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trappe</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mrs. Grim's Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>Marshall</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1889</b>
9. AGE (In years less birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Greenbury Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Dean Hancock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218 10 0077</b>	
17. INFORMANT <b>Mr. Lewis Green, Easton, Maryland</b>		Address <b>Prospect Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>a. i. d.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.0</b> DUE TO (c) <b>420.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/10/1959</b> to <b>8/19/1959</b> that I last saw the deceased alive on <b>8/10/1959</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>11 E. E. AVE. - Easton, Md.</b> DATE SIGNED <b>Arthur P. Evans</b>	
ACTUAL SIGNATURE <b>W. Frampton Carroll</b>		PHYSICIAN'S NAME (Type) <b>W. Frampton Carroll</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Frampton Carroll</b>		ADDRESS <b>Easton, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. Evans</b>	

CERTIFICATE OF DEATH

0583

10783

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	

1

2

3

THIS CERTIFICATE OF DEATH IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE JUDGE OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

9563

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 FilmG248 9-3-59 et

Reg. Dist. No.

09541

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>48X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Punta Gorda (Port Charlotte)</u>	
c. LENGTH OF STAY in 1b <u>DOA</u>		d. STREET ADDRESS <u>207 Normandy</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel Fairweather</u>		4. DATE OF DEATH <u>August 21 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 10, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Chaloner</u>		14. MOTHER'S MAIDEN NAME <u>Fairweather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Watter Smith - daughter -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Injury</u> <u>816X</u> DUE TO <u>Automobile Accident</u> Conditions, if any, which gave rise to immediate cause (b) <u>Automobile Accident</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>± hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left forearm; Laceration 2 knees &amp; left arm</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motor v. m.v.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>11:50</u> p. m. <u>8/21 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rte. 301</u>	20f. (City or town) (County) (State) <u>Queensdown</u> <u>QA.</u> <u>MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		DATE SIGNED <u>8/21/59</u>	
EXAMINER'S NAME (Type) <u>Irvin G. Hoyt MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial Aug 25/59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Laurens</u> <u>SC.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnie E. Leonard &amp; Son</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
ADDRESS <u>Easton</u>		DATE REC'D BY REGISTRAR <u>AUG 25 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20: From State Police  
8/25/57 as.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

9564

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10670

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Ruth E. Harrison</u>		4. DATE OF DEATH Month Day Year <u>August 16 19 59</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Joseph Phipps</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virginia Jones, daughter - with no. 10.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute &amp; chronic pyelonephritis</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Westinghouse St. Easton 16, Maryland</u> DATE SIGNED <u>19 Aug 1959</u>			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Tilghman Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Thomas</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9565

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09543

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>05x.2</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Johns</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 31, 1959</u>
9. AGE (In years last birthday) yrs. <u>9</u> Min. <u>45</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Rosetta Johns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital hypertrophy of the heart.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>754.5</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 31, 1959</u> , to <u>Aug 31, 1959</u> , that I last saw the deceased alive on <u>August 31, 1959</u> , and that death occurred at <u>7:10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Kurts</u>		ADDRESS (Street, city or town, state) <u>Denton, Md</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>E Paul Kurts MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>SEP 8 '59</u>		<u>Arthur L. Kline</u>	

VS A15 (4)  
15M 9/55

2080151XU3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9566

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09544

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>Green Anne</u> 17X-2	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u></u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 18 72</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home townhouse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Alice McDaniel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs Alice Brown, Queen Anne, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-18</u> , 19 <u>59</u> , to <u>8-31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-30</u> , 19 <u>59</u> , and that death occurred at <u>12:12 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u> DATE SIGNED <u>9-1-59</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u></u>	
PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		<u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown</u>		22d. LOCATION (City, town, or county) (State) <u>Hellsboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Vargis Moore &amp; Son, Inc., Easton, Md.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>SEP 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>	



CERTIFICATE OF DEATH

3280

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH April 12, 1942		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural	
9. SIGNATURE OF PHYSICIAN J. H. HARRIS		10. SIGNATURE OF REGISTRAR J. H. HARRIS	
11. SIGNATURE OF WITNESSES J. H. HARRIS		12. SIGNATURE OF DECEASED J. H. HARRIS	
13. SIGNATURE OF BURIAL OFFICIAL J. H. HARRIS		14. SIGNATURE OF FUNERAL HOME J. H. HARRIS	
15. SIGNATURE OF CORONER J. H. HARRIS		16. SIGNATURE OF JURY J. H. HARRIS	
17. SIGNATURE OF JUDGE J. H. HARRIS		18. SIGNATURE OF CLERK J. H. HARRIS	
19. SIGNATURE OF ASSISTANT CLERK J. H. HARRIS		20. SIGNATURE OF RECEPTIONIST J. H. HARRIS	
21. SIGNATURE OF TELEPHONE OPERATOR J. H. HARRIS		22. SIGNATURE OF MAIL ROOM J. H. HARRIS	
23. SIGNATURE OF RECORDS SECTION J. H. HARRIS		24. SIGNATURE OF STATISTICS SECTION J. H. HARRIS	
25. SIGNATURE OF LABORATORY J. H. HARRIS		26. SIGNATURE OF RADIOLOGY J. H. HARRIS	
27. SIGNATURE OF PATHOLOGY J. H. HARRIS		28. SIGNATURE OF ANATOMY J. H. HARRIS	
29. SIGNATURE OF PHYSIOLOGY J. H. HARRIS		30. SIGNATURE OF PSYCHOLOGY J. H. HARRIS	
31. SIGNATURE OF SOCIOLOGY J. H. HARRIS		32. SIGNATURE OF POLITICAL SCIENCE J. H. HARRIS	
33. SIGNATURE OF ECONOMICS J. H. HARRIS		34. SIGNATURE OF HISTORY J. H. HARRIS	
35. SIGNATURE OF GEOGRAPHY J. H. HARRIS		36. SIGNATURE OF ASTRONOMY J. H. HARRIS	
37. SIGNATURE OF METEOROLOGY J. H. HARRIS		38. SIGNATURE OF CLIMATE J. H. HARRIS	
39. SIGNATURE OF BOTANY J. H. HARRIS		40. SIGNATURE OF ZOOLOGY J. H. HARRIS	
41. SIGNATURE OF AGRICULTURE J. H. HARRIS		42. SIGNATURE OF FISHERIES J. H. HARRIS	
43. SIGNATURE OF FORESTRY J. H. HARRIS		44. SIGNATURE OF MINING J. H. HARRIS	
45. SIGNATURE OF METALLURGY J. H. HARRIS		46. SIGNATURE OF CHEMISTRY J. H. HARRIS	
47. SIGNATURE OF PHYSICS J. H. HARRIS		48. SIGNATURE OF MATHEMATICS J. H. HARRIS	
49. SIGNATURE OF ENGINEERING J. H. HARRIS		50. SIGNATURE OF ARCHITECTURE J. H. HARRIS	
51. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		52. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
53. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		54. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS	
55. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS		56. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
57. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		58. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
59. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		60. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS	
61. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS		62. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
63. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		64. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
65. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		66. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS	
67. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS		68. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
69. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		70. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
71. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		72. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS	
73. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS		74. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
75. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		76. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
77. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		78. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS	
79. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS		80. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
81. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		82. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
83. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		84. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS	
85. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS		86. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
87. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		88. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
89. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		90. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS	
91. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS		92. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
93. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		94. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
95. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		96. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS	
97. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS		98. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
99. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		100. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	

1

RECEIVED BY THE REGISTRAR  
APR 12 1942  
BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9567

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09545

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>136 Locust Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George H Johnson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/85</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA GREEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>314-03-7530</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old cerebrovascular accident</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> that I last saw the deceased alive on <u>D.O.A. on arrival at Memorial Hospital 8-23-59</u> and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u> DATE SIGNED <u>8-27-59</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Quibell, Easton Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

1887

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. File page 5 after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
BM 2/57

BALTIMORE, 18										09546	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tilghman</b>			c. LENGTH OF STAY IN lb <b>34 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tilghman</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>on a boat</b>					d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles A. Lowery</b>					4. DATE OF DEATH Month <b>Aug</b> Day <b>8</b> Year <b>19 59</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Aug 18, 1923</b>		9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waterman</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>oyster</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Wm. Joseph Lowery</b>					14. MOTHER'S MAIDEN NAME <b>Elsie M. Mattes</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>WWII</b>					16. SOCIAL SECURITY NO. <b>216 18 2593</b>		17. INFORMANT Address <b>Mrs. Wm.J. Lowery, Tilghman, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrocution</b> <b>9/4.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Heavy rain - Boarded boat being pumped out with electric pump</b>						
20c. TIME OF INJURY Month, Day, Year <b>3:45 p.m. 8/8/59 19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Knapps Narrows</b>		20f. (City or town) (County) (State) <b>Tilghman Talbot Md</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Louis M. Welch</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-11-59</b>				
EXAMINER'S NAME (Type) <b>WELTY</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Tilghman Methodist</b>			22d. LOCATION (City, town, or county) (State) <b>Tilghman, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Louis Moore</b>					ADDRESS <b>Tilghman, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>		

NEW STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

RESIDENCE: [illegible] OCCUPATION: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DECEASED'S SIGNATURE: [illegible]

EXAMINER'S SIGNATURE: [illegible]

DATE OF EXAMINATION: [illegible]

PLACE OF EXAMINATION: [illegible]

EXAMINER'S NAME: [illegible]

EXAMINER'S ADDRESS: [illegible]

EXAMINER'S PHONE: [illegible]

EXAMINER'S LICENSE NO.: [illegible]

EXAMINER'S EXPIRATION DATE: [illegible]

EXAMINER'S STATE: [illegible]

EXAMINER'S COUNTY: [illegible]

EXAMINER'S CITY: [illegible]

EXAMINER'S ZIP: [illegible]

EXAMINER'S TITLE: [illegible]

EXAMINER'S EMPLOYER: [illegible]

EXAMINER'S DEPARTMENT: [illegible]

EXAMINER'S DIVISION: [illegible]

EXAMINER'S SECTION: [illegible]

EXAMINER'S UNIT: [illegible]

EXAMINER'S TEAM: [illegible]

EXAMINER'S GROUP: [illegible]

EXAMINER'S CLASS: [illegible]

EXAMINER'S LEVEL: [illegible]

EXAMINER'S RANK: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9568

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> 05 x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>05 x 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Messick</u> Last <u>Messick</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16 1912</u> 47 yrs.
9. AGE (In years last birthday) <u>47</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Hudson Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Dean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Bertha Dean</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central hemiplegia</u> DUE TO <u>Cerebral hypoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> (31)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month <u>Aug</u> Day <u>31</u> Year <u>1959</u> Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 Aug 1959</u> , to <u>31 Aug 1959</u> , that I last saw the deceased alive on <u>31 Aug 1959</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Caroline, Maryland</u> DATE SIGNED <u>4 Sept 59</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>September 5, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Trautman &amp; Son, Federalsburg, Md.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>SEP 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino L. Kline</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
MRS. J. M. JONES		F		45		W		JAN 15 1918		HOME	
7. CAUSE OF DEATH		8. DISEASE		9. PRESENT ILLNESS		10. MEDICAL ATTENDANCE		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
HEART DISEASE		CORONARY ARTERY DISEASE		ANGINA PECTORIS		DR. J. M. JONES					
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. MARITAL STATUS		16. OCCUPATION		17. EDUCATION		18. RELIGION	
BALTIMORE, MD.		JAN 1 1873		MARRIED		HOUSEWIFE		HIGH SCHOOL		METHODIST	
19. NAME OF PHYSICIAN		20. NAME OF SURGEON		21. NAME OF PATHOLOGIST		22. NAME OF BACTERIOLOGIST		23. NAME OF ANATOMIST		24. NAME OF HISTOLOGIST	
DR. J. M. JONES											
25. NAME OF FUNERAL HOME		26. NAME OF BURIAL PLACE		27. NAME OF CEMETERY		28. NAME OF INTERMENT		29. NAME OF CREMATION		30. NAME OF INCINERATION	
J. M. JONES & SONS		GREENWOOD CEMETERY		BALTIMORE, MD.		INTERMENT					
31. NAME OF REGISTRAR		32. NAME OF CLERK		33. NAME OF ASSISTANT CLERK		34. NAME OF DEPUTY REGISTRAR		35. NAME OF DEPUTY CLERK		36. NAME OF DEPUTY ASSISTANT CLERK	
J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES	

1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

9569

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09547

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN TB <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>403 South St</u>		d. STREET ADDRESS <u>403 South St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Carrie M. Rasin</u>		4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/32</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invalid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>George P. Rasin</u>	
14. MOTHER'S MAIDEN NAME <u>Carrie Thomas</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Mrs. Carrie Rasin Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Imbecile</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lewis M. Weir</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WEIR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-21-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		22d. LOCATION (City, town, or county) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Dashiell, Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>			

FOR STATE  
HEALTH DEPT

3568

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1957

CERTIFICATE OF DEATH

MADE IN MARYLAND

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>
DATE OF DEATH <i>Jan 15 1957</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DISEASE OR INJURY <i>Myocardial Infarction</i>		OTHER CAUSE <i>None</i>	
SIGNS AND SYMPTOMS <i>None</i>		TREATMENT <i>None</i>	
FINDINGS AT AUTOPSY <i>None</i>		LABORATORY TESTS <i>None</i>	
SIGNATURE OF EXAMINER <i>Dr. J. Smith</i>		DATE <i>Jan 15 1957</i>	
SIGNATURE OF WITNESS <i>John Doe</i>		DATE <i>Jan 15 1957</i>	
SIGNATURE OF CLERK <i>John Doe</i>		DATE <i>Jan 15 1957</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9570

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09548

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>8</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Sheek</u>		4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4<sup>th</sup> 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. AGE (In years last birthday) <u>88</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA</u>	
11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Moses Gochnour</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wyandt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>July</u> , 19 <u>59</u> , that I lost saw the deceased olive on <u>July</u> , 19 <u>59</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u>		DATE SIGNED <u>July 12, 1959</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug. 12, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greenboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore &amp; Son</u>		24a. REC'D BY REGISTRAR <u>Aug 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Harris</u>			



100000

THE STATE OF

# CERTIFICATE OF DEATH

9570

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 10

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF WITNESS</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF FUNERAL HOME</p>		<p>14. SIGNATURE OF COUNTY CLERK</p>	
<p>15. SIGNATURE OF VICE-MAYOR</p>		<p>16. SIGNATURE OF MAYOR</p>	

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THE STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9571

CERTIFICATE OF DEATH

09550

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Duaneanne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>17X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Snaw</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 21, 1959</u>
9. AGE (In years, last birthday) <u>1</u> yrs. <u>5</u> months <u>1</u> day <u>5</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ronald Burdette Snaw</u>		14. MOTHER'S MAIDEN NAME <u>Joyce Perkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Joyce Perkins</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxemia</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pretermaturity</u> DUE TO (c) <u>Placenta Previa</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/21</u> , 19 <u>59</u> , to <u>8/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/21</u> , 19 <u>59</u> , and that death occurred at <u>1:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Quantico, Md.</u> DATE SIGNED <u>9/26/59</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Incineration</u>		22b. DATE THEREOF <u>8/26/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hrp</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>-</u> ADDRESS <u>-</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, giving the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

9584 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09551

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NR OXFORD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Oxford</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>None</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Sparklin</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/5/1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boat Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Sparklin</b>		14. MOTHER'S MAIDEN NAME <b>Ella Lowery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-4325</b>	
17. INFORMANT <b>Margaret Sparklin</b>		Address <b>Oxford, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(DIED ON BOAT WHILE FISHING—BODY</b> DUE TO (c) <b>DISCOVERED NEXT DAY)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>IMMED</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PRIOR CARDIAC CONDITION</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>8-22 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>CHOPTANK RIVER</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Louis S. Welty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>LOUIS S. WELTY</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>8-24-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oxford</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulois, Greensboro, Md.</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

FOR STATE  
HEALTH DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

9572

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>11 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home for Aged Women</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Hill</b> <b>17 x - 2</b>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNIE MATILDA SPRY</b>		4. DATE OF DEATH Month Day Year <b>Aug. 19, 19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1874</b>
9. AGE (In years lost birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ran rooming house</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John L. Spry</b>		14. MOTHER'S MAIDEN NAME <b>Emma Cahoon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Home Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 July</b> , 19 <b>59</b> , to <b>19 Aug</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12 Aug</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Maurice E. Newnam</b>		ADDRESS (Street, city or town, state) <b>Easton, Md.</b>	
DATE SIGNED <b>21 Aug 59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Thurston Harrison</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 21, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Church Hill, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		ADDRESS <b>Easton, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kneass</b>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9573

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09553

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		d. STREET ADDRESS <u>05X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Starks</u> Last <u>Starks</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Starks</u>	
14. MOTHER'S MAIDEN NAME <u>Eveline Tubbs</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>013-22-8743</u>	
16. SOCIAL SECURITY NO. <u>013-22-8743</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.0</u> DUE TO <u>a. i. d.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>a. i. d.</u> DUE TO (c) <u>a. i. d.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ca of prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Aug 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/18</u> , 19 <u>59</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. E. Conf. M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>8/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hillsboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Roswell</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR <u>AUG 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>			

1957

## CERTIFICATE OF DEATH

9273

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. RACE <i>White</i>		4. DATE OF BIRTH <i>Jan 1, 1900</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>	
6. DATE OF DEATH <i>Dec 1, 1957</i>		7. TIME OF DEATH <i>10:00 AM</i>		8. PLACE OF DEATH <i>Home</i>		9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>John Doe</i>		12. SIGNATURE OF CORONER <i>John Doe</i>		13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>		25. SIGNATURE OF WITNESS <i>John Doe</i>	
26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>	
36. SIGNATURE OF WITNESS <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>		49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>	
56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>	
66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>		73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>		85. SIGNATURE OF WITNESS <i>John Doe</i>	
86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>	
96. SIGNATURE OF WITNESS <i>John Doe</i>		97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

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9574

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg, 05x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		d. STREET ADDRESS <u>RFD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Essie Mae Thomas</u>		4. DATE OF DEATH Month Day Year <u>August 28, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1910</u> 49 yrs.
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Will Connley</u>		14. MOTHER'S MAIDEN NAME <u>Edna Connely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>/</u>	
17. INFORMANT Address <u>Carrie Owens, Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>524 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-28</u> , 19 <u>59</u> , to <u>8-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-28</u> , 19 <u>59</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u> DATE SIGNED <u>8-30-59</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.		DATE SIGNED <u>8-30-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Palmetto Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Palmetto FLA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Welch</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9575 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

09555

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Freemont St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pierre</u> Middle <u>Lamotte</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7 1959</u>
9. AGE (In years, last birthday) <u>32</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>2</u> Hours <u>32</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Liswood Leon Fountain</u>		14. MOTHER'S MAIDEN NAME <u>Matthe Virginia Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>prematurity</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>32 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-7-59</u> , 19 <u>59</u> , to <u>8-9-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-9-59</u> , 19 <u>59</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm M. Preiser</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels md</u> DATE SIGNED <u>8-11-59</u>	
PHYSICIAN'S NAME (Type) <u>Wm M. Preiser</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>8/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hsp</u>		22d. LOCATION (City, town, or county) (State) <u>Pasadena md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Harris</u>		ADDRESS <u>Freemont St</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9576

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

119558

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>05 X. 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>A</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Cherry</u>		14. MOTHER'S MAIDEN NAME <u>JANE Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Clarence Ringgold</u>		Address <u>Ridgely, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infra cardiac thrombosis</u> DUE TO (c) <u>Coronary thrombosis &amp; myo cardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u> <u>5 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 Aug</u> , 19 <u>59</u> , to <u>4 Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 Aug</u> , 19 <u>59</u> , and that death occurred at <u>12:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		DATE SIGNED <u>6 Aug 59</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 8, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenboro</u>	22d. LOCATION (City, town, or county) (State) <u>Greenboro Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Leonard</u> ADDRESS <u>Verdon, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9577

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 09557

1. PLACE OF DEATH a. COUNTY <u>TALBOT CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md.</u>		c. LENGTH OF STAY IN IB <u>25 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Asa</u> Last <u>Voshell</u>		4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>17</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Smith Voshell</u>		14. MOTHER'S MAIDEN NAME <u>Sarah WALLS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-30-8237</u>	
17. INFORMANT <u>Ms. Edward Voshell</u>		Address <u>Centerville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>a. H. D</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>stroke several yrs ago</u>	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour a. m. <u>11</u> p. m. <u>00</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/21</u> , 19 <u>54</u> , to <u>8/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/21</u> , 19 <u>59</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. Evans Cox</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton Md.</u> DATE SIGNED <u>8/3/59</u>	
PHYSICIAN'S NAME (Type) <u>P. Evans Cox</u>		<u>Easton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Aug 4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9578

## CERTIFICATE OF DEATH

Reg. Dist. No.

09558

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bozman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS. Lottie M. Watson</u>		4. DATE OF DEATH Month Day Year <u>Aug 17 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr Robert Lloyd</u>		14. MOTHER'S MAIDEN NAME <u>Martha Brookman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Percy F. Watson, son</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerotic cardio vas. d.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia, cerebrovascular occluded.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-1-59</u> , to <u>8-17-59</u> , that I last saw the deceased alive on <u>8-17-59</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>St Michaels MD</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8-17-59</u>	
PHYSICIAN'S NAME (Type) <u>Larry M Reeser MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 20 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Graham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Orange Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stamilton Harrison</u>		ADDRESS <u>St Michaels MD</u>	
24. REC'D BY REGISTRAR <u>Aug 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Kram</u>	

CERTIFICATE OF DEATH

9578

41554

<p>1. NAME OF DECEASED <i>John H. Brown</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>65</i></p>		<p>4. DATE OF BIRTH <i>1880</i></p>		<p>5. PLACE OF BIRTH <i>Frederick, Md.</i></p>	
<p>6. OCCUPATION <i>Farmer</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1905</i></p>		<p>9. PLACE OF MARRIAGE <i>Frederick, Md.</i></p>		<p>10. DATE OF DEATH <i>1945</i></p>	
<p>11. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>12. MANNER OF DEATH <i>Natural</i></p>		<p>13. PLACE OF DEATH <i>Home</i></p>		<p>14. DATE OF INTERMENT <i>1945</i></p>		<p>15. PLACE OF INTERMENT <i>Cemetery</i></p>	
<p>16. SIGNATURE OF PHYSICIAN <i>John H. Brown</i></p>		<p>17. SIGNATURE OF DECEASED <i>John H. Brown</i></p>		<p>18. SIGNATURE OF WITNESSES <i>John H. Brown</i></p>		<p>19. SIGNATURE OF REGISTRAR <i>John H. Brown</i></p>		<p>20. SIGNATURE OF CLERK <i>John H. Brown</i></p>	

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.